1992

GUIDE

To Health Insurance for People with Medicare

- ★ WHAT MEDICARE PAYS AND DOESN'T PAY
- ★ TYPES OF PRIVATE HEALTH INSURANCE
- ★ TIPS ON SHOPPING FOR PRIVATE HEALTH INSURANCE
- ★ MEDIGAP INSURANCE TO BE STANDARDIZED IN 1992

Developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration of the U.S. Department of Health and Human Services.

— NOTICE —

Listed in the back of this booklet are the addresses and telephone numbers of each of the state agencies on aging and the state insurance departments. They are available to assist you with any questions you may have about private insurance to supplement Medicare. Suspected violations of the laws governing the marketing of these policies should generally be reported to your state insurance department since states are responsible for the regulation of insurance within their boundaries. There are federal penalties for certain violations concerning Medicare supplement insurance or so-called "Medigap" policies. It is, for example, a federal offense for an insurance agent to indicate that he or she represents the Medicare program or any other federal agency in order to sell a policy. The federal toll-free telephone number for registering such complaints is:

1-800-638-6833

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TABLE OF CONTENTS

New Medicare Beneficiary's Right to Medigap Coverage

Congress has established a 6-month open enrollment period for buying Medicare supplement health insurance (Medigap). The law, which applies to all Medigap policies becoming effective after November 5, 1991, guarantees that for 6 months immediately following enrollment in Medicare medical insurance (Part B), persons aged 65 or older cannot be denied Medigap insurance because of health problems.

During this period, the company must offer you all the different types of Medigap policies it sells and cannot delay the issuance or effective date or discriminate in the pricing of any such policy, based on your medical condition, health status, claims experience, or receipt of health care. The company can, however, apply a pre-existing conditions clause during the first 6 months of the policy's life.

Many individuals are enrolled automatically in Medicare Part B as soon as they turn 65, or they sign up during an initial 7-month enrollment period which begins 3 months before they turn 65. If you are in this group, your Medigap open enrollment period starts as soon as your Part B coverage starts.

Others may delay their enrollment in Part B. If you continue to work after age 65 and choose to be covered by an employer insurance plan or are covered under a spouse's employment-related insurance instead of by Medicare Part B, you will have a special 7-month enrollment period for Part B, beginning with the month you stop work or are no longer covered under the employer plan, whichever comes first. Your 6-month Medigap open enrollment period starts when your Part B coverage begins.

Otherwise, if you are eligible for, but are not enrolled in, Medicare Part B, you will be eligible to elect coverage in the future during the annual general enrollment period from January through March. Once your Part B coverage is effective (in July of the year in which you enroll), you will have the regular 6-month guaranteed open enrollment period in which to select a Medigap policy.

Your Medicare card tells you the effective dates for your Part A and/or Part B coverage. To figure whether you are entitled to the 6-month Medigap open enrollment period (or some part of it), add 6 months to the effective date of your Part B coverage. If the date is in the future and you qualified for Medicare by reason of age rather than by reason of disability, you are eligible for the Medigap open enrollment period. If the date is in the past, you either were never eligible for the window (because the closing date occurred before November 5, 1991) or you have missed it.

If you are under age 65, disabled, and enrolled in Medicare Parts A and B, you are not eligible for the open enrollment period guarantees.

A more detailed explanation of the Medicare program can be found in THE MEDICARE HANDBOOK.
Copies are available from any Social Security Administration office, or by writing:

MEDICARE PUBLICATIONS
Health Care Financing Administration
6325 Security Boulevard
Baltimore, Md. 21207.

SOME BASIC THINGS YOU SHOULD KNOW

If you are like most older Americans covered by Medicare, there are aspects of the federal health insurance program that you do not fully understand. You may be uncertain about what Medicare covers and doesn't cover and how much it pays toward your medical expenses. And, like most other beneficiaries, you want to know what, if any, additional health insurance you should buy.

This booklet will help you clear up those uncertanties. It will give you a better understanding of your Medicare benefits and the types of private health insurance available to supplement Medicare. It will also identify the gaps in your Medicare coverage and provide tips on shopping for insurance to fill those gaps.

Insurance Counseling

Although the information in this booklet will help you to be a better informed and a more careful purchaser, it is generally advisable to seek the advice of others before buying. Consult a friend or relative knowledgeable about insurance matters, or ask whether local senior citizen organizations or governmental agencies have insurance counseling services. Several states currently offer counseling services and several others are considering introducing programs in the near future. Counseling is available in California, Delaware, Florida, Idaho, Illinois, Indiana, Iowa, Maryland, Massachusetts, Michigan, Missouri, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, Tennessee, Texas, Vermont, Washington and Wisconsin. (See page 23 for telephone numbers.)

Medigap Standardized in 1992

Counseling services may be of particular value to you this year as new laws go into effect standardizing and simplifying Medicare supplement insurance policies, which are also called "Medigap" and "Med Supp" policies. Most states are expected to adopt new Medigap regulations by July 30, 1992. Among other things, the new regulations will limit the number of different Medigap policies that can be sold in a state to no more than 10 standard benefit packages (see page 10). The new standards will apply only to policies that are sold after your state changes its Medigap regulations. If you already have a Medigap policy that is guaranteed renewable, you will not be required to switch to one of the 10 new standard policies. You may, however, want to consider switching if you can get better coverage at a price you can afford and an insurer is willing to sell you a replacement policy. If you do switch, you will not be allowed to go back to the old policy.

Before discussing the new standard policies and the other types of private insurance available to supplement Medicare, it will be helpful to briefly review your Medicare benefits and to identify the payment gaps.

WHAT IS MEDICARE?

Medicare is a federal health insurance program for people 65 or older, people of any age with permanent kidney failure, and certain disabled people under 65. It is administered by the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services. The Social Security Administration provides information about the program and handles enrollment .

Two Parts of Medicare

Medicare has two separate parts--hospital insurance (Part A) and medical insurance (Part B). Part A is financed through part of the Social Security (FICA) tax paid by all workers and their employers. You do not have to pay a monthly premium for Medicare Part A if you or your spouse are entitled to benefits under either the Social Security or Railroad Retirement systems, or worked a sufficient period of time in federal, state, or local government employment to be insured. If you do not meet the qualifications for premium-free Part A benefits, you may purchase the

coverage if you are at least age 65 and meet certain requirements. You also may buy Part A if you are under age 65 and had been entitled to Medicare under the disability provisions, your disability benefits were terminated because of your work and earnings, but you still have the same disabling impairment. The Part A premium in 1992 is $192 per month.

Part B is optional and is offered to all beneficiaries when they become entitled to Part A. It also may be purchased by most persons age 65 or over who do not qualify for premium-free Part A coverage. The Part B premium in 1992 is $31.80 each month.

You are automatically enrolled in Part B when you become entitled to Part A unless you state that you don't want it. Although you do not have to purchase Part B, it is an excellent buy because the federal government pays about 75 percent of the program costs. Your Medicare card shows the coverage you have [Hospital Insurance (Part A), Medical Insurance (Part B), or both] and the date your protection started. If you only have one part of Medicare, you can get information about getting the other part from any Social Security office.

MEDICARE HOSPITAL INSURANCE BENEFITS (PART A)

When all program requirements are met, Medicare Part A will help pay for medically necessary inpatient care in a hospital, skilled nursing facility or psychiatric hospital, and for hospice care. In addition, Part A pays the full cost of medically necessary home health care and 80 percent of the approved cost for durable medical equipment supplied under the home health benefit.

Benefit Periods

Medicare Part A benefits are paid on the basis of benefit periods. A benefit period begins the first day you receive a Medicare covered service in a hospital. It ends when you have been out of a hospital or skilled nursing facility for 60 days in a row. It also ends if you remain in a skilled nursing facility but do not receive any skilled care there for 60 days in a row. If you enter a hospital again after 60 days, a new benefit period begins. All Part A benefits are renewed except for any lifetime reserve days or psychiatric hospital benefits that were used.

DEFINITIONS OF TERMS

Actual Charge: The amount a physician or supplier actually bills for a particular medical service or supply.

Approved Amount: The amount Medicare determines to be reasonable for a covered service. It may be less than the actual charge.

Assignment: An arrangement whereby a physician or medical supplier agrees to accept the Medicare approved amount for covered services and supplies as payment in full and is paid directly by Medicare. Providers who do not accept assignment of Medicare claims can charge more than the Medicare approved amount and are paid directly by the Medicare beneficiary. Medicare then reimburses the beneficiary its share of the approved amount.

Benefit Period: A benefit period begins the first day a beneficiary receives Medicare covered inpatient hospital services. It ends when the beneficiary has been out of a hospital or skilled nursing facility for 60 days in a row. It also ends if the beneficiary remains in a skilled nursing facilty but does not receive skilled care there for 60 days in a row. A new benefit period starts when inpatient hospital services are again required. The number of benefit periods is unlimited.

Coinsurance: The portion or percentage of Medicare approved amounts for covered services that a beneficiary is responsible for paying.

Deductible: The amount of expense a beneficiary must first incur in approved amounts before Medicare begins payment for covered services.

Excess Charge: The difference between the Medicare approved amount for a service or supply covered by Medicare and the actual charge.

Medigap Insurance: Private insurance specifically designed to supplement Medicare's benefits by filling in some of the payment gaps.

Participating Physician and Supplier: A physician or supplier who agrees to accept assignment on all Medicare claims.

There is no limit to the number of benefit periods you can have for hospital or skilled nursing facility care.

Inpatient Hospital Care

If you are hospitalized, Medicare will pay all charges for covered hospital services during the first 60 days of a benefit period except for the deductible. The Part A deductible in 1992 is $652 per benefit period. You are responsible for the deductible. For the 61st through the 90th day, Part A pays for all covered services except for coinsurance of $163 a day in 1992. You are responsible for the coinsurance. Under Part A, you also have a lifetime reserve of 60 days for inpatient hospital care. They may be used whenever you need more than 90 days of inpatient hospital care in a benefit period. When a reserve day is used, Part A pays for all covered services except for coinsurance of $326 a day in 1992. Again, the coinsurance is your responsibility. Once used, reserve days are not renewed.

Gaps in Medicare Inpatient Hospital Coverage:

- You pay $652 deductible on first admission to hospital in each benefit period.
- You pay $163 daily coinsurance for days 61 through 90.
- You pay $326 daily coinsurance for each lifetime reserve day used.
- Coverage beyond 90 days in any benefit period is limited to the number of lifetime reserve days available and used.
- No coverage for the first 3 pints of whole blood or units of packed cells used in each year in connection with covered services. To the extent the 3-pint blood deductible is met under Part B, it does not have to be met under Part A.
- No coverage for a private hospital room, unless medically necessary, or for a private duty nurse.
- No coverage for personal convenience items, such as a telephone or television in a hospital room.
- No coverage for care that Medicare deems to be medically unnecessary or for care in a hospital not certified by Medicare.
- No coverage for care received outside the United States and its territories, except under limited circumstances in Canada and Mexico.

Skilled Nursing Facility Care

To qualify for Medicare coverage for skilled nursing facility (SNF) care you must have been in a hospital at least three consecutive days (not counting the day of discharge) before entering a SNF. The admission must be for the same condition for which you were treated in the hospital (or for a condition that arose while you are receiving care in the SNF for the hospital-related condition) and generally must be within 30 days of your discharge from the hospital. Your physician must certify that you need, and receive, skilled nursing or skilled rehabilitation services on a daily basis. Medicare Part A can help pay for up to 100 days of skilled care in a SNF during a benefit period. All covered services for the first 20 days of care are fully paid by Medicare. All covered services for the next 80 days are paid by Medicare except for a daily coinsurance amount. The daily coinsurance in 1992 is $81.50. You are responsible for the coinsurance. If you require more than 100 days of care in a benefit period, you are responsible for all charges beginning with the 101st day.

A SNF is a special kind of facility that primarily furnishes skilled nursing and rehabilitation services. It may be a separate facility or a distinct part of another facility, such as a hospital. Medicare benefits are payable only if you require daily skilled care which, as a practical matter, can only be provided in a SNF on an inpatient basis, and the care is

provided in a SNF certified by Medicare. Medicare will not pay for your stay in a SNF if the services you receive are mainly personal care or custodial services, such as help in walking, getting in and out of bed, eating, dressing, bathing and taking medicine.

Gaps in Medicare Skilled Nursing Facility Coverage:

- You pay $81.50 daily coinsurance for days 21 through 100 in each benefit period.
- No coverage beyond 100 days in a benefit period.
- No coverage for care in a non-participating nursing home or for just custodial care in a skilled nursing facility.
- No coverage of the blood deductible (see list of gaps under inpatient hospital care).

Home Health Care

Part A pays the full cost of medically necessary home health visits if you are homebound. Coverage includes the part-time or intermittent services of a skilled nurse. A Medicare-certified home health agency can also furnish the services of physical and speech therapists. If you require any of these services, are confined to your home, and are under the care of a physician, Part A can also pay for other services. They include necessary part-time or intermittent home health aide services, occupational therapy, medical social services, and medical supplies. Coverage is also provided for a portion of the cost of durable medical equipment provided under a plan of care set up and overseen by a physician.

Gaps in Medicare Home Health Coverage:

- No coverage for full-time nursing care.
- No coverage for drugs, or for meals delivered to your home.
- You pay 20 percent of the reasonable charge for durable medical equipment.
- No coverage for homemaker services that are primarily to assist you in meeting personal care or housekeeping needs.

Hospice Care

Medicare beneficiaries certified as terminally ill may choose to receive hospice care rather than regular Medicare benefits for their terminal illness. Part A can pay for two 90-day hospice benefit periods, a subsequent period of 30 days, and a subsequent extension of unlimited duration.

If you enroll in a Medicare-certified hospice program you will receive medical and support services necessary for symptom management and pain relief. When these services–which are most often provided in your home–are furnished by a Medicare-certified facility, the coverage includes: physician services, nursing care, medical appliances and supplies (including drugs for symptom management and pain relief), short-term inpatient care, counseling, therapies, and home health aide and homemaker services.

Medicare's Part A and Part B deductibles do not apply to services and supplies furnished under the hospice benefit. You must pay only limited charges for outpatient drugs and inpatient respite care. In the event you require medical services for a condition unrelated to the terminal illness, regular Medicare benefits are available. When regular benefits are used, you are responsible for the applicable Medicare deductible and coinsurance amounts.

Gaps in Medicare Hospice Coverage:

- You pay limited charges for inpatient respite care and outpatient drugs.
- You pay deductibles and coinsurance amounts when regular Medicare benefits are used for treatment of a condition other than the terminal illness.

Psychiatric Hospital Care

Part A helps pay for no more than 190 days of inpatient care in a participating psychiatric hospital in your lifetime. Once you have used 190 days, Part A does not pay for any more inpatient care in a psychiatric hospital. However, psychiatric care in general hospitals, rather than in free-standing psychiatric hospitals, is not subject to this 190-day limit. Inpatient psychiatric care in a general hospital is treated the same as other Medicare inpatient hospital care.

If you are a patient in a psychiatric hospital on the first day of your entitlement to Medicare, there are additional limitations on the number of hospital days that Medicare will pay for.

Gaps in Medicare Inpatient Psychiatric Hospital Care:

- No coverage for the cost of care if you need more than 190 days of such specialized treatment in your lifetime.

MEDICARE MEDICAL INSURANCE (PART B) BENEFITS

Part B helps pay for medically necessary physician services no matter where you receive them—at home, in the doctor's office, in a clinic or hospital. It also covers related medical services and supplies, medically necessary outpatient hospital services, X-rays and laboratory tests. Coverage is also provided for certain ambulance services and the in-home use of durable medical equipment, such as wheelchairs and hospital beds.

Additionally, Part B covers physical therapy, occupational therapy, and speech pathology services in a doctor's office, as an outpatient, or in your home. Mental health services are covered along with mammograms and Pap smears. And if you qualify for home health care but do not have Medicare Part A, then Part B pays for all covered home health visits. Outpatient prescription drugs generally are not covered by Part B. The exceptions include certain drugs furnished hospice enrollees, non-self administrable drugs provided as part of a physician's services and special drugs, such as drugs furnished during the first year after an organ transplantation and erythropoetin for home dialysis patients. When you use your Part B benefits, you will be required to pay the first $100 (the annual deductible) each calendar year. The deductible must represent charges for services and supplies covered by Medicare. It also must be based on the Medicare approved amounts, not the actual charges billed by your physician or medical supplier.

After you meet the deductible, Medicare Part B generally pays 80 percent of the Medicare approved amount for covered services you receive the rest of the year. You are responsible for the other 20 percent. You have no deductible or coinsurance for home health services. You do, however, have to pay 20 percent of the Medicare approved amount for durable medical equipment supplied under the home health benefit. If a doctor or supplier does not accept assignment of your Medicare claim and charges more than Medicare's approved amount, you are liable for the difference. The difference to be paid is called the "excess charge" or "balance billing." Be mindful, however, that there are certain charge limitations mandated by federal law, and that some states also limit physician charges.

Medicare Approved Amount

The Medicare approved amount for physician services covered by Part B is based on a national fee schedule. The schedule, which went into effect January 1, 1992, assigns a dollar value to each physician service based on work, practice costs and malpractice insurance costs. It was developed by the Health Care Financing Administration pursuant to the physican payment reform program legislated by Congress in the Omnibus Budget Reconciliation Act (OBRA) of 1989. Under the new payment system, each time you go to a physician for a service covered by Medicare the amount Medicare will recognize for that service will be taken from the national fee schedule. Medicare generally pays 80 percent of that amount.

Because you cannot tell in advance whether the approved amount and the actual charge for covered services and supplies will be the same, always ask your physicians and medical suppliers whether they accept assignment of Medicare claims.

Accepting Assignment

Those who take **assignment** on a Medicare claim agree to accept the Medicare-approved amount as payment in full. They are paid directly by the Medicare carrier, except for the deductible and coinsurance that you must pay.

For example, if you go to a participating physician or, if your physician accepts assignment, and the Medicare approved amount for the service you receive is $200, you would be billed $120: $100 for the annual deductible plus 20 percent of the remaining $100. Medicare would pay the other $80. Having met the deductible for the year, the next time you used Part B services furnished by a participating physician or medical supplier, or, if the physician or supplier accepts assignment, you would be responsible for only 20 percent of the Medicare approved amount.

Physicians and suppliers who sign Medicare participation agreements accept assignment on all Medicare claims. Their names and addresses are listed in *THE MEDICARE PARTICIPATING PHYSICIAN/SUPPLIER DIRECTORY*. The directory is distributed to senior citizen organizations, all local Social Security and Railroad Retirement Board offices, all hospitals, and all state and area offices of The Administration on Aging. The directory may also be obtained free of charge from the insurance carrier that processes Medicare Part B claims in your area (see the back of *THE MEDICARE HANDBOOK* for the list of carrier addresses), or you can call the carrier for the names of Medicare-participating physicians or suppliers.

While your physician or supplier may not be a Medicare-participating physician or supplier, ask before you receive any services whether he or she will accept assignment of your Medicare claim. Many physicians and suppliers accept assignment on a case-by-case basis. If your physician or supplier does not accept assignment, you are responsible for the bill. The law requires the physician or supplier to file a claim with Medicare, but when they don't accept assignment, you are responsible for paying the bill. Medicare will reimburse you its share of the approved amount.

In certain situations non-participating providers of services are required by law to accept assignment. For instance, all physicians and qualified laboratories must accept assignment for Medicare–covered clinical diagnostic laboratory tests. Physicians also must accept assignment for covered services provided to beneficiaries with incomes low enough to qualify for Medicaid payment of their Medicare cost-sharing requirements (see page 19).

Physician Charge Limits

Physicians who do not accept assignment of a Medicare claim are limited as to the amount they can charge you for covered services. In 1992, the most a physician can charge you for services covered by Medicare is 120 percent of the fee schedule amount for nonparticipating physicians. In 1993 it will be 115 percent. Physicians who knowingly, willfully, and repeatedly charge more than these amounts are subject to sanctions. If you think you have been charged more than the acceptable level, contact you Medicare carrier.

Another federal law requires doctors who do not accept assignment for elective surgery to give you a written estimate of your costs before the surgery if the total charge will be $500 or more. If the doctor did not give you a written estimate, you are entitled to a refund of any amount you paid in excess of the Medicare approved amount.

You should also be aware that any doctor who provides you with services that he or she knows or believes Medicare will determine to be medically unnecessary and thus will not pay for, is required to so notify you in writing before performing the service. If written notice is not given, and you did not know that Medicare would not pay, you cannot be held liable to pay for that service. However, if you did receive written notice and signed an agreement to pay for the service yourself, you will be held liable to pay.

Gaps in Medicare Coverage for Doctors and Medical Suppliers:

- You pay $100 annual deductible.
- You pay 20% coinsurance.
- You pay all charges in excess of the Medicare approved amount for unassigned claims.
- You pay 50% of approved charges for most outpatient mental health treatment.
- You pay all charges in excess of Medicare's maximum yearly limit of $600 for independent physical or occupational therapists.
- No coverage for most self-administerable prescription drugs or immunizations (except for pneumococcal and hepatitis B vaccinations).
- No coverage for routine eye examinations or eyeglasses (except prosthetic lenses, if needed, after cataract surgery).
- No coverage for hearing aids or routine hearing loss examinations.
- No coverage for most services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury (except for mammography screenings).
- No coverage for dental care or dentures.
- No coverage for acupuncture treatment.
- No coverage for care received outside the United States and its territories, except under limited circumstances in Canada and Mexico.
- No coverage for supportive devices and routine foot care except when a medical condition affecting the lower limbs (such as diabetes) requires care by a podiatrist or doctor of medicine.
- No coverage for services of naturopaths, Christian Science practitioners, immediate relatives, or charges imposed by members of your household.
- No coverage for the first 3 pints of whole blood or units of packed cells used in each year in connection with covered services. To the extent the 3-pint blood deductible is met under Part A, it does not have to be met under Part B.
- No coverage for routine physicals and other screening services.

Medicare Benefit Charts

As you can see from the preceding information, Medicare does not pay the entire cost for all services covered by the program. You or your Medicare supplemental insurance company must pay certain deductibles and coinsurance amounts and charges in excess of Medicare's approved amount for covered services and supplies.

The charts on pages 8 and 9 describe Medicare benefits only. The "You Pay" column itemizes expenses you are responsible for and must pay out of your own pocket or through the purchase of some type of private insurance as described in this booklet.

MEDICARE (PART A): HOSPITAL INSURANCE-COVERED SERVICES PER BENEFIT PERIOD (1)

Services	Benefit	Medicare Pays**	You Pay**
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days	All but $652	$652
	61st to 90th day	All but $163 a day	$163 a day
	91st to 150th day*	All but $326 a day	$326 a day
	Beyond 150 days	Nothing	All costs
POSTHOSPITAL SKILLED NURSING FACILITY CARE You must have been in a hospital for at least 3 days and enter a Medicare-approved facility generally within 30 days after hospital discharge. (2)	First 20 days	100% of approved amount	Nothing
	Additional 80 days	All but $81.50 a day	up to $81.50 a day
	Beyond 100 days	Nothing	All costs
HOME HEALTH CARE Medically necessary skilled care, home health aide services, medical supplies, etc.	Part-time or intermittent nursing care and other services for as long as you meet criteria for benefits.	100% of approved amount; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
HOSPICE CARE Full scope of palliative medical and support services available to the terminally ill.	As long as doctor certifies need.	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
BLOOD	Blood	All but first 3 pints per calendar year.	For first 3 pints.***

* 60 reserve days may be used only once. ** These figures are for 1992 and are subject to change each year.

*** To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

(1) A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital or skilled nursing facility for 60 days in a row or remain in a skilled nursing facility but do not receive skilled care there for 60 days in a row.

(2) Neither Medicare nor private Medigap insurance will pay for most nursing home care.

MEDICARE (PART B): MEDICAL INSURANCE-COVERED SERVICES PER CALENDAR YEAR

Services	Benefit	Medicare Pays	You Pay
MEDICAL EXPENSE Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, etc.	Medicare pays for medical services in or out of the hospital.	80% of approved amount (after $100 deductible).	$100 deductible,* plus 20% of approved amount and any charge above approved amount.**
CLINICAL LABORATORY SERVICES	Blood tests, biopsies, urinalysis, etc.	100% of approved amount.	Nothing for services.
HOME HEALTH CARE Medically necessary skilled care, home health aide services, medical supplies, etc.	Part-time or intermittent nursing care and other services for as long as you meet criteria for benefits.	100% of approved amount; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
OUTPATIENT HOSPITAL TREATMENT Reasonable and necessary services for the diagnosis or treatment of an illness or injury.	Unlimited if medically necessary.	80% of approved amount (after $100 deductible).	Subject to deductible plus 20% of approved amount.
BLOOD	Blood	80% of approved amount (after $100 deductible and starting with 4th pint).	First 3 pints plus 20% of approved amount for additional pints (after $100 deductible).***

* Once you have had $100 of expense for covered services in 1992, the Part B deductible does not apply to any further covered services you receive for the rest of the year.

** In addition to Medicare coinsurance, you pay for charges higher than the amount approved by Medicare unless the doctor or supplier agrees to accept Medicare's approved amount as full payment for services rendered *(see page 6)*.

*** To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

TYPES OF PRIVATE HEALTH INSURANCE

Whether you need private health insurance in addition to your Medicare protection is a decision that only you can make. As you saw from the review of your Medicare benefits, Medicare does not offer complete health insurance protection. Private health insurance, if carefully chosen, and if you can afford the additional expense, can help fill many of the gaps.

Most experts feel that it is a good investment to buy the additional protection that private health insurance can provide. But you should shop carefully and buy a policy that offers the kind of additional help you think you need most. Do not be misled by the claims of a private insurer or a private insurance agent that you will be "fully" protected by buying private insurance.

A variety of private insurance policies are available to help pay for medical expenses, services and supplies that Medicare covers only partly or not at all. The basic types of policies include: (1) Medicare supplement, or "Medigap" policies, which are specifically designed to pay some of the money amounts that Medicare does not pay for covered services; (2) coordinated care plans (these include health maintenance organizations [HMOs] and competitive medical plans [CMPs]), from which you purchase health care services directly for a fixed monthly premium; (3) continuation or conversion of a policy you have when you reach 65; (4) nursing home or long-term care policies, which pay cash amounts for each day of covered nursing home care; (5) hospital indemnity policies, which pay cash amounts for each day of inpatient hospital services; and, (6) specified disease policies, which pay only when you need treatment for the disease insured against.

Medigap

Medigap insurance is private health insurance designed specifically to supplement Medicare's benefits by filling in some of the gaps in Medicare coverage. Some Medigap policies provide coverage for Medicare's deductibles and most pay the coinsurance amounts. Some policies also pay for limited health services not covered by Medicare. The definition of a Medigap policy provided by federal law excludes employment-related group health plans. For example, coverage offered to former employees or former members of labor organizations is not Medigap insurance. Limited benefit plans such as indemnity policies are also not Medigap insurance. The statutory definition of Medigap, however, includes all "Medicare wrap-around" products sold by HMOs to individuals.

If you are in the market for Medigap insurance, you should compare benefits and premiums and be satisfied that the insurer is reputable before buying. Keep in mind that Medicare pays only for services it determines to be medically necessary and only the amount it determines to be reasonable. Most Medigap policies do not pay for services Medicare finds unnecessary, and some may not pay for charges in excess of Medicare's approved amount.

You should be aware that major changes affecting Medigap insurance will go into effect this year. Most states are expected to adopt new regulations no later than July 30 that will limit the number of different Medigap policies that can be sold in a state to no more than 10 standard benefit packages. Medigap policies in force before your state adopts the new standards will not be affected by the change. Insurers, however, will be required to meet pre-standardization regulations that are in effect in most states and will continue to apply to the old policies. Those regulations require that, as a minimum, a Medigap policy must provide the following benefits:

- Coverage for either all of the Medicare Part A inpatient hospital deductible ($652 per benefit period in 1992) or none of it. Insurers are not permitted to pay just a part of the deductible.
- Coverage for the Part A daily coinsurance amount ($163 per day in 1992) for the 61st through the 90th day of hospitalization in each Medicare benefit period.

- Coverage for the Part A daily coinsurance amount ($326 per day in 1992) for each of Medicare's 60 non-renewable, lifetime hospital inpatient reserve days used.
- After all Medicare hospital benefits are exhausted, coverage for 90% of the hospital charges that otherwise would have been paid by Medicare. This benefit is limited to a maximum of 365 days of additional hospital care during the policyholder's lifetime.
- Coverage for the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells per calendar year unless replaced in accordance with federal regulations.
- Coverage for the Part B coinsurance amount (generally 20% of Medicare-eligible expenses) after the policyholder pays the $100 Part B annual deductible.

While nearly all of the states have minimum benefit standards, there may be differences in basic Medigap policies from state to state. So, to find out what standards are in effect in your state and whether they apply to your current Medigap policy, check with your state insurance department. Again, the minimum benefit standards listed above apply only to certain Medigap policies in force before the new standards take effect in your state. Moreover, both the old and new standards apply only to private policies meeting the definition of a "Medicare supplemental policy" under federal law. That definition specifically excludes policies or plans of employers and labor organizations, and limited benefit policies.

Standardized Medigap Policies. Recent changes in federal law mandated national standardization of Medigap policies. These changes require that insurers offer no more than 10 "standardized" Medigap benefit plans that have been developed by the National Association of Insurance Commissioners (NAIC). The 10 standard plans include a basic policy offering a "core" benefit package. Each of the other nine has a different combination of additional benefits, but they all include the core package. Insurers will not be permitted to change the combination of benefits in any of the 10 standard policies, or change the letter designations that range from "A" through "J". They may, however, add names or titles to the letter designations.

While a state may limit the number of plans available in the state to fewer than 10, each state adopting the new regulations must at least ensure that the basic policy (Plan A) is approved for sale in the state. Medigap insurers are not required to offer all of the plans approved for sale in each of the individual states, but each must offer the basic policy. To find out when the new standardized policies will be available in your state, and how many of the 10 have been or are likely to be approved for sale, check with your state insurance department.

States that already had their own standardization programs for Medigap policies in effect when the federal law was changed may not be affected by the new standards. In these few states, the Secretary of Health and Human Services has authority to waive the federal standardization requirements, allowing them to retain their alternative standardization programs. The benefit packages available in these "alternative" states should, however, include the "core" benefits required by federal law. Again, you should check with your state insurance department to determine what specific Medigap benefit plans are available.

Remember, the new regulations will not apply to Medigap policies in force before the new requirements take effect in your state. If you already have a Medigap policy that is guaranteed renewable, you will not have to switch to one of the new standard policies, but you may want to consider such a move if it is to your advantage and an insurer is willing to sell you one. On the other hand, once your state adopts the new regulations, you will be able to buy only a standard policy. Until then, you can buy any of various policies approved for sale in your state. (See page ii for information on the right of certain Medicare beneficiaries to buy Medigap insurance).

Unlike some other types of health coverage that restrict where and from whom you can receive care,

Standard Medigap Plans

Following is a list of the 10 standard plans and the benefits provided by each:

PLAN A (the basic policy) consists of these core benefits:

- Coverage for the Part A coinsurance amount ($163 per day in 1992) for the 61st through the 90th day of hospitalization in each Medicare benefit period.
- Coverage for the Part A coinsurance amount ($326 per day in 1992) for each of Medicare's 60 non-renewable lifetime hospital inpatient reserve days used.
- After all Medicare hospital benefits are exhausted, coverage for 100% of the Medicare Part A eligible hospital expenses. Coverage is limited to a maximum of 365 days of additional inpatient hospital care during the policyholder's lifetime. This benefit is paid either at the rate Medicare pays hospitals under its Prospective Payment System or another appropriate standard of payment.
- Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells per calendar year unless replaced in accordance with federal regulations.
- Coverage for the 20% coinsurance amount for Part B services after the $100 annual deductible is met.

PLAN B includes the core benefits *plus:*

- Coverage for the Medicare Part A inpatient hospital deductible ($652 per benefit period in 1992).

PLAN C includes the core benefits *plus:*

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care coinsurance amount ($81.50 per day for days 21 through 100 per benefit period in 1992).
- Coverage for the Medicare Part B deductible ($100 per calendar year in 1992).
- Coverage for medically necessary emergency care in a foreign country.

PLAN D includes the core benefits *plus:*

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care coinsurance amount.
- Coverage for medically necessary care in a foreign country.
- Coverage for at-home recovery. The at-home recovery benefit pays up to $1600 per year for short-term, at-home assistance with activities of daily living (bathing, dressing, personal hygiene, etc.) for those recovering from an illness, injury or surgery. There are various benefit requirements and limitations.

PLAN E includes the core benefits *plus:*

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- Coverage for medically necessary emergency care in a foreign country.
- Coverage for preventive medical care. The preventive medical care benefit pays up to $120 per year for such things as a physical examination, flu shot, serum cholesterol screening, hearing test, diabetes screenings and thyroid function test.

PLAN F **includes the core benefits *plus:***

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- Coverage for the Medicare Part B deductible.
- Coverage for medically necessary emergency care in a foreign country.
- Coverage for 100% of Medicare Part B excess charges.*

PLAN G **includes the core benefits *plus:***

- Coverage for the Medicare Part A deductible.
- Coverage for skilled nursing facility care daily coinsurance amount.
- Coverage for 80% of the Medicare Part B excess charges.*
- Coverage for medically necessary emergency care in a foreign country.
- Coverage for at-home recovery.

PLAN H **includes the core benefits *plus:***

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- Coverage for medically necessary emergency care in a foreign country.
- Coverage for 50% of the cost of prescription drugs up to a maximum annual benefit of $1,250 after the policyholder meets a $250 per year deductible (this is called the "basic" prescription drug benefit).

PLAN I **includes the core benefits *plus:***

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- Coverage for 100% of Medicare Part B excess charges.*
- Basic prescription drug coverage (see PLAN H for description.
- Coverage for medically necessary emergency care in a foreign country.
- Coverage for at-home recovery.

PLAN J **includes the core benefits *plus:***

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility daily coinsurance amount.
- Coverage for the Medicare Part B deductible.
- Coverage for 100% of Medicare Part B excess charges.*
- Coverage for medically necessary emergency care in a foreign country.
- Coverage for preventive medical care.
- Coverage for at-home recovery.
- Coverage for 50% of the cost of prescription drugs up to a maximum annual benefit of $3,000 after the policyholder meets a $250 per year deductible (this is called the "extended" drug benefit).

* These four plans pay a specified percentage of the difference between the Medicare approved amount for covered services and supplies and charge limitations established by the Medicare program or state law.

10 STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS

CORE BENEFITS	PLAN A	PLAN B	PLAN C	PLAN D	PLAN E	PLAN F	PLAN G	PLAN H	PLAN I	PLAN J
Part A Hospital (Days 61-90)	X	X	X	X	X	X	X	X	X	X
Lifetime Reserve Days 91-150)	X	X	X	X	X	X	X	X	X	X
365 Life Hosp. Days-100%	X	X	X	X	X	X	X	X	X	X
Parts A and B Blood	X	X	X	X	X	X	X	X	X	X
Part B Coinsurance-20%	X	X	X	X	X	X	X	X	X	X
ADDITIONAL BENEFITS	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**
Skilled Nursing Facility Coinsurance (Days 21-100)			X	X	X	X	X	X	X	X
Part A Deductible		X	X	X	X	X	X	X	X	X
Part B Deductible			X			X				X
Part B Excess Charges						100%	80%		100%	100%
Foreign Travel Emergency			X	X	X	X	X	X	X	X
At-Home Recovery				X			X		X	X
Prescription Drugs								1	1	2
Preventive Medical Care					X					X

Core Benefits pay the patient's share of Medicare's approved amount for physician services (20%) after $100 annual deductible, the patient's cost of a long hospital stay ($163/day for days 60-90, $326/day for days 91-150, all approved costs not paid by Medicare after day 150 to a total of 365 days lifetime), and charges for the first 3 pints of blood not covered by Medicare.

Two prescription drug benefits are offered:

1. a "basic" benefit with $250 annual deductible, 50% coinsurance and a $1,250 maximum annual benefit (Plans H and I above), and
2. an "extended" benefit (Plan J above) containing a $250 annual deductible, 50% coinsurance and a $3,000 maximum annual benefit.

Each of the 10 plans has a letter designation ranging from "A" through "J". Insurance companies are not permitted to change these designations or to substitute other names or titles. They may, however, add names or titles to these letter designations. While companies are not required to offer all of the plans approved for sale by the individual states, they all must make Plan A available if they sell any of the other 9 in a state.

traditional Medigap policies pay the same supplemental benefits, regardless of your choice of doctor or other health care provider. If Medicare pays for a service, wherever provided, the traditional Medigap policy must pay its regular share of benefits. You may, however, have to pay a higher premium for this freedom of choice.

Automatic Filing of Medigap Claims. If you have a Medigap policy you may be able to have your Medicare claim automatically filed with your Medigap insurer. Under certain circumstances, you do not have to file a separate claim with your Medigap insurer in order to have payment made directly to your doctor or supplier. By law, your Medicare carrier will send your claim automatically to the Medigap insurer when three conditions are met for a Medicare Part B claim.

The first condition is that your doctor or supplier must have signed a participation agreement with Medicare to accept assignment of Medicare claims for all patients who are Medicare beneficiaries. Secondly, your policy must be a Medigap policy as described on page 10. Thirdly, you must indicate on the Medicare claim form that you wish payment of Medigap benefits to be made to the participating doctor or supplier.

When these conditions are met, your Medicare carrier will process the Medicare claim, send the claim to the Medigap insurer and send you an Explanation of Medicare Benefits. Your Medigap insurer will pay benefits directly to your doctor or supplier and send you a notice that they have done so.

If your Medigap insurer refuses to pay the doctor directly when these three conditions are met, you should report this to your state insurance department. For more information on Medigap automatic claim filing, contact your local Medicare carrier. Look in *The Medicare Handbook* for the name and telephone number of the carrier for your area.

Medicare SELECT. A new Medicare supplemental health insurance product called "Medicare SELECT" is scheduled to be introduced in 15 states beginning in 1992. The states where these policies are expected to be available are Alabama, Arizona, California, Florida, Indiana, Kentucky, Michigan, Minnesota, Missouri, North Dakota, Ohio, Oregon, Texas, Washington and Wisconsin. Medicare SELECT is private Medigap insurance that will be offered in the designated states by insurance companies and health maintenance organizations (HMOs) in essentially the same way that traditional Medigap policies are made available. And just like other Medigap insurance, Medicare SELECT will be required to meet certain federal standards and will be regulated at the state level.

The principal difference between Medicare SELECT and traditional Medigap insurance is that Medicare beneficiaries who buy a Medicare SELECT policy are expected to be charged a lower premium in return for agreeing to use the services of designated health care professionals. These health care professionals, called "preferred providers," will be selected by the carriers. Each issuer of a Medicare SELECT policy, whether it be an insurance company or HMO, will have its own network of preferred providers.

When a Medicare SELECT policyholder receives covered services from a preferred provider, Medicare will pay its share of the approved charges, and the Medicare SELECT insurer will cover up to the limits of the policy. Medicare SELECT also will pay supplemental benefits for emergency health care furnished by providers outside the preferred provider network. In general, Medicare SELECT policies will deny payment or pay less then the full benefit if the policyholder goes outside the network for non-emergency services. Medicare, however, will still pay its share of approved charges in such situations.

During the three-year period currently authorized under federal law, Medicare SELECT will be evaluated to determine if it should be made available throughout the nation. Companies selling Medicare SELECT policies are required to provide for the continuation of coverage if the Medicare SELECT program is not continued. Furthermore, beneficiaries who have Medicare SELECT policies will have the option to purchase any traditional Medigap policy that the company offers and which includes

comparable or lesser benefits than those provided by the Medicare SELECT policy if the program is not extended.

In some areas of the country, Medicare SELECT-type "wrap around" products have been offered until now by HMOs and other insurers with preferred provider networks. Because of the statutory limitation on Medicare SELECT to 15 states, these plans will no longer be open to new enrollees in states which have not been designated as Medicare SELECT states once these states have adopted the new Medigap standardization rules.

Coordinated Care Plans That Contract With Medicare

Coordinated care plans, also called managed care and prepayment plans, include health maintenance organizations (HMOs), competitive medical plans (CMPs), and some health care prepayment plans (HCPPs). They might be thought of as a combination insurance company and doctor/hospital. Like an insurance company, they cover health care costs in return for a monthly premium, and like a doctor or hospital, they arrange for health care.

HMOs and CMPs, and some HCPPs, also coordinate all your health care services to make sure you are receiving appropriate care. If you belong to an HMO or CMP that has a contract with Medicare, you probably do not need Medigap insurance. However, if you join an HMO or CMP and later decide to disenroll and return to fee-for-service care and want to buy a Medigap policy, you may not be able to get the coverage on favorable terms, especially if you have a preexisting health condition.

In a coordinated care plan, a network of health care providers (doctors, hospitals, skilled nursing facilities, etc.) generally offers comprehensive, coordinated medical services to plan members on a prepaid basis. The plan provides you with all Medicare hospital and medical benefits available in the plan's service area. Services usually must be obtained from the professionals and facilities that are part of the plan. If you enroll in a coordinated care plan that has a contract with Medicare, Medicare makes a monthly payment to the plan. Additionally, most plans charge monthly premiums and nominal copayments. You do not have to pay the Medicare deductible and coinsurance amounts, and usually there are no other charges--no matter how many times you visit the doctor, are hospitalized, or use other covered services.

An HMO or CMP that has a contract with Medicare must provide or arrange for the full range of Part A and B services (if you are covered under both parts of Medicare). Some also provide benefits beyond what Medicare pays for, such as preventive care, prescription drugs, dental care, hearing aids and eyeglasses. Some HMOs contract with HCFA as HCPPs and are able to provide or arrange for both Medicare Part A and Part B services. However, some HCPPs only provide or arrange for Part B services exclusively, and some HCPPs may even provide less than the full range of Part B services.

You are eligible to enroll in a coordinated care plan if you live in a plan's service area, are enrolled in Medicare Part B, do not have permanent kidney failure, and have not elected the Medicare hospice benefit. The organization may limit enrollment to a specific open enrollment period each year. HCPPs may also impose other enrollment requirements. Before joining a plan, be sure to read the plan's membership materials carefully to learn your rights and the nature and extent of your coverage. If you live in an area that is served by more than one coordinated care plan, compare benefits, costs and other features to determine which plan best suits your needs at a price you can afford.

If you belong to an HMO or a CMP that has a "risk" contract with Medicare, Medicare will not pay its share for any non-emergency benefits you receive from providers outside of the HMO or CMP. That is, you are "locked in" to receiving all your benefits (except for emergency care) from the HMO or CMP.

As noted in the previous section, coordinated care plans in certain states, whether they contract with Medicare or not, will be authorized to issue Medicare SELECT policies which are a form of Medigap insurance.

Group Insurance

There are two principal sources of group insurance: employers and voluntary associations.

Employer Group Insurance for Retirees. Many people, upon reaching age 65, already have private insurance coverage, often purchased through their or their spouse's current employer or union membership. If you have such coverage, find out if it can be continued or converted to suitable individual coverage when you or your spouse retires. Check the price and the benefits, including benefits for your spouse.

Group health insurance that is continued or converted after retirement usually has the advantage of having no waiting periods or exclusions for preexisting conditions, and the coverage is usually based on group premium rates, which are often lower than the premium rates for individually purchased policies. One note of caution, however. If you have a spouse under 65 who was covered under the prior policy, make sure you know what effect your continued or converted coverage will have on his or her insurance protection.

Furthermore, since employer group insurance policies do not have to comply with the federal minimum benefit standards for Medigap policies, it is important to determine what coverage your specific retirement policy provides. It will not necessarily be "Medicare supplement" insurance.

Special Rules for Working People Age 65 or Over. If you are 65 or over and you or your spouse work, then Medicare may be secondary payer to any employer group health plan (EGHP) coverage you may have. This means that the employer plan pays first on your hospital and medical bills. If the employer plan does not pay all of your expenses, Medicare may pay secondary benefits to supplement the amount paid by the employer plan.

Employers who have 20 or more employees are required to offer the same health benefits, under the same conditions, to employees age 65 or over, and to employees' spouses who are 65 or over, that they offer to younger employees and spouses. EGHP coverage of employers of 20 or more employees is primary to Medicare.

You may accept or reject coverage under the EGHP. If you accept the employer plan, it will be your primary payer. If you do not accept the employer plan's coverage, Medicare will be the primary payer for Medicare-covered health services that you receive. If you reject the employer plan, you can buy supplemental insurance on your own, but an employer can not provide you with a plan that pays supplemental benefits for Medicare-covered services, or subsidize such coverage. An employer may, however, offer a plan that pays for health care services not covered by Medicare, such as hearing aids, routine dental care, and physical checkups.

Special Rules for Certain Disabled Medicare Beneficiaries. Medicare is also secondary for certain people under age 65 who are entitled to Medicare based on disability (other than those with permanent kidney failure) and who have large group health plan (LGHP) coverage. An LGHP is a plan of, or contributed to by, an employer or employee organization that covers the employees of at least one employer with 100 or more employees.

This requirement applies to those who have LGHP coverage as an employee, employer, self-employed person, business associate of an employer, or a family member of any of these people. An LGHP must not treat any of these people differently because they are disabled and have Medicare. The term employee here includes both those who are actively working despite their disability (such as disabled Medicare beneficiaries engaged in a trial work period) and those who are not actively working, but whom the employer treats as employees. Medicare determines whether an individual is considered to be an employee.

Disabled persons also have the option of accepting or rejecting LGHP coverage. If they reject the plan, Medicare becomes their primary payer, and the employer may not provide or subsidize supplemental coverage, except for items and services not covered by Medicare.

Special Rules for Medicare Beneficiaries with Permanent Kidney Failure. Medicare is secondary payer to EGHPs for 18 months for beneficiaries who have Medicare solely because of permanent kidney failure. This requirement applies only to those with permanent kidney failure, whether they have their own coverage under an EGHP or are covered under an EGHP as dependents. EGHPs are primary payers during this period without regard to the size of the EGHP or the number of employees. The 18-month period begins with the earlier of:

- The first month in which the person becomes entitled to Medicare Part A; or
- The first month in which an individual would have been entitled to Part A if he had filed an application for Medicare benefits.

However, EGHPs may be primary for an additional 3 months, or a total of up to 21 months: the first three months of dialysis (a period during which an individual generally is not eligible for Medicare benefits) plus the first 18 months of Medicare eligibility or entitlement. After the period of up to 21 months expires, Medicare is primary payer for entitled individuals and the EGHP is secondary. The Health Care Financing Administration pamphlet titled *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services* contains more information about Medicare and kidney disease. You can get a free copy from the Social Security Administration or the Consumer Information Center, Department 59, Pueblo, CO 81009 (refer to publication number 603V).

Association Group Insurance. Many organizations, other than employers, offer various kinds of group health insurance coverage to their members. Just because you are buying through a group does not mean that you are getting a low rate. Group insurance can be as expensive as or more costly than comparable coverage under individual policies. Be sure you understand the benefits included and then compare prices.

The following types of coverage are generally limited in scope and are not substitutes for Medigap insurance or coordinated care plans.

Long-Term Care Insurance

Nursing home and long-term care insurance are available to cover custodial care in a nursing facility (NF) as well as certain care in the home. Policies also are available to pay for care in a skilled nursing facility (SNF) after your Medicare benefits run out (see page 3 for an explanation of the Medicare skilled nursing care benefit).

If you are in the market for nursing home or long-term care insurance, be sure you know which types of nursing homes and services are covered by the different policies available. And if you buy a policy, make sure it does not duplicate skilled nursing facility (SNF) coverage provided by any coordinated care plan or other coverage you have. It is important to remember that custodial care (the type of care most persons in nursing homes require) is not covered by Medicare or most Medigap policies. The only care in nursing homes that Medicare covers is skilled nursing care or skilled rehabilitation care that is provided in a Medicare-certified SNF.

For more detailed information about long-term care insurance, request a copy of A Shopper's Guide to Long-Term Care Insurance *from either your state insurance department or:*

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS
120 W. 12th Street, Suite 1100
Kansas City, MO 64105

You may also obtain a copy of Guide to Choosing a Nursing Home *by writing to:*

MEDICARE PUBLICATIONS
Health Care Financing Administration
6325 Security Boulevard
Baltimore, MD 21207

Hospital Indemnity Insurance

Hospital indemnity coverage is insurance that pays a fixed amount for each day you are hospitalized up to a designated number of days. Some coverage may have added benefits such as surgical benefits or skilled nursing home confinement benefits. Some

policies have a maximum number of days or a maximum payment amount. Generally, a hospital indemnity policy will pay the specified daily amount regardless of any other health insurance coverage you have, but other group health insurance may coordinate benefits with hospital confinement indemnity insurance sold on a group basis.

Specified Disease Insurance

Specified disease insurance, which is not available in some states, provides benefits for only a single disease, such as cancer, or a group of specified diseases. The value of such coverage depends on the chance you will get the specific disease or diseases covered. Benefits are usually limited to payment of a fixed amount for each type of treatment. Benefits are not designed to fill gaps in Medicare coverage.

DO YOU NEED MORE INSURANCE?

Before buying insurance to supplement Medicare, ask yourself whether you need private health insurance in addition to Medicare. Not everyone does.

Medicaid Recipients

Low-income people who are eligible for Medicaid usually do not need additional insurance. Individuals who are eligible for regular Medicaid benefits qualify for certain health care benefits beyond those covered by Medicare, such as long-term nursing home care. If you have Medigap insurance and later become eligible for Medicaid, you can request that the benefits and premiums be suspended for up to two years while you are covered by Medicaid. Should you become ineligible for Medicaid benefits during the two years, your Medigap policy is automatically reinstituted if you give proper notice and begin paying premiums again.

Coordinated Care Plan Enrollees

If you are a Medicare beneficiary enrolled in a health maintenance organization (HMO) or competitive medical plan (CMP) that has a contract with Medicare, you probably do not need a Medigap policy (see page 16).

Assistance For Low-Income Elderly

Limited financial assistance is available through Medicaid for paying Medicare premiums, deductibles, and coinsurance amounts for certain low-income elderly and disabled beneficiaries. If your annual income is below the national poverty level and you do not have access to many financial resources, you qualify for government assistance in paying Medicare monthly premiums and the Medicare deductibles and coinsurance amounts.

The national poverty income levels for 1992 will be announced in February 1992. In 1991 the limits were $6,620 for one person and $8,880 for a family of two. The maximum annual income for qualifying for assistance may vary by state. You cannot have resources such as bank accounts or stocks and bonds worth more than $4,000 for an individual or $6,000 for a couple.

If you qualify, this financial assistance is available through your state's medical assistance (Medicaid) office. For further information contact your state or local social service agency and ask about the "Qualified Medicare Beneficiary" program.

TIPS ON SHOPPING FOR HEALTH INSURANCE

Shop Carefully Before You Buy. Policies differ widely as to coverage and cost, and companies differ as to service. Contact different companies and compare the premiums before you buy. Also check the loss ratios of different policies. Insurers must pay at least 65 cents in benefits for each premium dollar they receive on individual Medigap policies, and 75 cents on group Medigap contracts.

Don't Buy More Policies Than You Need. Duplicate coverage is costly and unnecessary. A single comprehensive policy is better than several policies with overlapping or duplicate coverage. A new federal law significantly tightens the prohibition against the offering of duplicative coverage to Medicare beneficiaries by prohibiting any duplication of benefits and removing the exception for policies that pay without respect to the existence of other cover-

age. The new federal law prohibits the sale of a Medicare supplement policy to a person who already has another health insurance policy that provides coverage for any of the same benefits. The reverse is also true. The sale of a health insurance policy is prohibited if it duplicates coverage of a Medicare supplement policy. Now, when you buy a Medigap policy to replace another policy, you must state in writing that you intend to cancel the first policy after the new policy becomes effective. Anyone who sells you a policy in violation of these tough, new anti-duplication provisions may be subject to heavy criminal and/or civil penalties.

Consider Your Alternatives. Depending on your health care needs and finances, you may want to consider continuing the group coverage you have at work; joining an HMO, CMP or other coordinated care plan; buying a Medigap policy, or buying a long-term care insurance policy .

Check For Preexisting Condition Exclusions. In evaluating a policy, you should determine whether it limits or excludes coverage for existing health conditions. Many policies do not cover health problems that you have at the time of purchase. Preexisting conditions are generally health problems you went to see a physician about within the six months before the date the policy went into effect. Don't be misled by the phrase "no medical examination required." If you have had a health problem, the insurer might not cover you for expenses connected with that problem. However, most states require Medigap policies to cover preexisting conditions after the policy has been in effect for 6 months.

Beware of Replacing Existing Coverage. Be careful when buying a replacement Medigap policy. Make sure you have a good reason for switching from one policy to another--you should only switch for better benefits, better service, or a more affordable price. On the other hand, don't keep inadequate policies simply because you have had them a long time. You don't get credit with a company just because you've paid for a policy many years. If you decide to buy a replacement Medigap policy, the replacing insurer must waive any time periods applicable to preexisting conditions exclusions to the extent that payment for those conditions was already excluded from the old policy. In other words, you must be given credit for the time spent under the old policy in determining when such restrictions expire under the new policy. You must also sign a statement that you intend to terminate the policy to be replaced. Do not cancel the first policy until you are sure that you want to keep the new policy.

Prohibited Marketing Practices. It is unlawful for anyone selling Medigap insurance to use high pressure tactics to force or frighten you into buying a policy, or to make fraudulent or misleading comparisons to get you to switch from one company or policy to another. "Cold lead" advertising also is prohibited. This tactic often involves deceptive mailings to identify those who might be interested in buying insurance. If you fill in and return the card enclosed in the mailing, the card may be sold to an insurance agent who will try to sell you a policy.

Be Aware of Maximum Benefits. Most policies have some type of limit on benefits. They may restrict either the dollar amount that will be paid for treatment of a condition or the number of days of care for which payment will be made. Some insurance policies (but not Medigap policies) pay less than the Medicare approved amounts for hospital outpatient medical services and for services provided in a doctor's office. Others do not pay anything toward the cost of those services.

Check Your Right to Renew. Most states now require that newly issued Medigap policies be guaranteed renewable. This means that the company can refuse to renew your policy only if you do not pay the premiums, you made significant misrepresentations about your health status on the application, or it cancels all policies of that type in the state. Even though your policy may be guaranteed renewable, the company may adjust the premiums from time to time. Beware of old policies that let the company refuse to renew on an individual basis. These policies provide the least permanent coverage.

Be Aware That Policies to Supplement Medicare Are Neither Sold Nor Serviced by the State or Federal Governments. State insurance departments approve policies sold by insurance companies but approval only means the company and policy meet requirements of state law.

Do not believe statements that insurance to supplement Medicare is a government-sponsored program. If anyone tells you that he or she is from the government and later tries to sell you an insurance policy, report that person to your state insurance department or federal authorities.

This type of misrepresentation is a violation of federal and state law. It is also unlawful for a company or agent to falsely claim that a policy has been approved for sale in any state in which it has not received state approval, or to use fraudulent means to gain approval.

Know With Whom You're Dealing. A company must meet certain qualifications to do business in your state. This is for your protection. Agents also must be licensed by your state and may be required by the state to carry proof of licensure showing their name and the company they represent. If the agent cannot verify that he or she is licensed, do not buy from that person. A business card is not a license.

Keep Agents' and/or Companies' Names, Addresses and Telephone Numbers. Write down the agents' and/or companies' names, addresses and telephone numbers or ask for a business card that provides all that information.

Take Your Time. Do not be pressured into buying a policy by an agent who tells you that there is a limited enrollment period. Principled salespeople will not rush you. If you are not certain whether a program is worthy, ask the salesperson to explain it to a friend. Keep in mind, however, that there is a limited time period in which new Medicare Part B enrollees can buy Medigap insurance without conditions being imposed (see page ii).

If You Decide To Buy, Complete the Application Carefully. Do not believe an insurance agent who tells you that your medical history on an application is not important. Some companies ask for detailed medical information. If you leave out any of the medical information requested, coverage could be refused for a period of time for any medical condition you neglected to mention. The company also could deny a claim for treatment of an undisclosed condition and/or cancel your policy.

Look For an Outline of Coverage. You must be given a clearly worded summary of the policy . . . READ IT CAREFULLY.

Do Not Pay Cash. Pay by check, money order or bank draft made payable to the insurance company, not to the agent or anyone else. Get a receipt with the insurance company's name, address and telephone number for your records.

Policy Delivery or Refunds Should be Prompt. The insurance company should deliver a policy within 30 days. If it does not, contact the company and obtain in writing the reason for the delay. If 60 days go by without a response, contact your state insurance department.

Use the "Free-Look" Provision. Insurance companies must give you at least 30 days to review a Medigap policy. If you decide you don't want the policy, send it back to the agent or company within 30 days of receiving it and ask for a refund of all premiums you paid. Contact your state insurance department if you have a problem getting a refund.

For Your Protection

Federal criminal and civil penalties can be imposed against anyone who sells you a policy that duplicates coverage you already have, unless you sign a statement declaring that the first policy will be cancelled. There are also penalties for claiming that a policy meets legal standards for federal certification when it does not, and for using the mail for the delivery of advertisements offering for sale a Medigap policy in a state in which it has not received state approval.

Additionally, it is illegal under federal law for an individual or company to misuse the names, letters,

symbols or emblems of the U.S. Department of Health and Human Services, the Social Security Administration, or the Health Care Financing Administration. It also is illegal to use the names, letters, symbols or emblems of their various programs.

This law is aimed primarily at mass marketers who use this information on mail solicitations to either imply or claim that the product they are selling–whether it be insurance or something else–has either been endorsed or is being sold by the U.S. Government. The advertising literature is designed to look like it came from a government agency.

If you believe you have been the victim of any unlawful sales practices, contact your state insurance department immediately (see pages 23 to 26). If you believe that federal law has been violated, you may call the toll-free number listed in the front of this booklet. In most cases, however, your state insurance department can offer the most assistance in resolving insurance–related problems.

MEDICARE SUPPLEMENT INSURANCE COUNSELING

California
1-800-927-4357

Delaware
(302) 739-4251

Florida*
(904) 922-3132

Idaho
(208) 334-2250

Illinois
(217) 782-0004

Indiana*
1-800-622-4461
(317) 232-2395

Iowa
(515) 281-5705

Maryland
1-800-243-3425
(410) 225-1100

Massachusetts
(617) 727-7750

Michigan*
(517) 335-1702

Missouri*
1-800-726-7390
(314) 751-2640

New Jersey
1-800-792-8820
(609) 292-4303
(609) 984-6953

New Mexico
1-800-432-2080
(505) 827-7640

New York*
(518) 455-4312

North Carolina
(919) 733-0111

Ohio*
1-800-686-1526

Oregon*
(503) 378-4484

Tennessee*
1-800-252-2816
(615) 741-4955

Texas
(512) 463-6515

Vermont*
(802) 828-3301

Washington
(206) 753-2408

Wisconsin
1-800-242-1060
(608) 266-8944

* **NOTE**: These states do not include extensive one-on-one counseling or are in the process of establishing comprehensive counseling programs. Calls to 800 numbers can only be made within the respective states.

Each State has its own laws and regulations governing all types of insurance. The offices listed in this section are responsible for enforcing these laws, as well as providing the public with information about insurance.

Alabama
Alabama Insurance Department
135 South Union Street
Montgomery, AL 36130-3401
(205) 269-3550

Alaska
Alaska Division of Insurance
3601 C Street, Suite 740
Anchorage, AK 99503-5934
(907) 562-3626

American Samoa
American Samoa Insurance Department
Office of the Governor
Pago Pago, AS 96797
011-684/633-4116

Arizona
Arizona Insurance Department
Consumer Affairs and Investigation Division
3030 N. Third Street
Phoenix, AZ 85012
(602) 255-4783

Arkansas
Arkansas Insurance Department
Consumer Service Division
400 University Tower Bldg.
12th and University Streets
Little Rock, AR 72204
(501) 371-1813

California
California Insurance Department
Consumer Services Division
3450 Wilshire Boulevard
Los Angeles, CA 90010
1-800-927-4357

Colorado
Colorado Insurance Division
1560 Broadway, Suite 850
Denver, CO 80202
(303) 894-7499

Connecticut
Connecticut Insurance Department
153 Market Street
P.O. Box 816
Hartford, CT 06142-0816
(203) 297-3800

Delaware
Delaware Insurance Department
841 Silver Lake Boulevard
Dover, DE 19901
(302) 739-4251

District of Columbia
District of Columbia Insurance
613 G Street, NW
Room 619
P.O. Box 37200
Washington, DC 20001-7200
(202) 727-8017

Florida
Florida Department of Insurance
State Capitol
Plaza Level Eleven
Tallahassee, FL 32399-0300
Toll Free (Within State)
1-800-342-2762
(904) 488-0030

Georgia
Georgia Insurance Department
2 Martin L. King, Jr., Dr.
Room 716 West Tower
Atlanta, GA 30334
(404) 656-2056

Guam
Guam Insurance Department
855 W. Marine Drive
P.O. Box 2796
Agana, Guam 96910
011-671/477-1040

Hawaii
Hawaii Department of Commerce
and Consumer Affairs Insurance Division
P.O. Box 3614
Honolulu, HI 96811
(808) 586-2790

Idaho
Idaho Insurance Department
Public Service Department
500 South 10th Street
Boise, ID 83720
(208) 334-3102

Illinois
Illinois Insurance Department
320 West Washington Street
4th Floor
Springfield, Il 62767
(217) 782-4515

Indiana
Indiana Insurance Department
311 West Washington Street
Suite 300
Indianapolis, IN 46204
Toll Free (Within State)
1-800-622-4461
(317) 232-2395

Iowa
Iowa Insurance Division
Lucas State Office Bldg.
E. 12th & Grand Sts.
6th Floor
Des Moines, IA 50319
(515) 281-5705

Kansas
Kansas Insurance Department
420 S.W. 9th Street
Topeka, KS 66612
(913) 296-3071

Kentucky
Kentucky Insurance Department
229 West Main Street
P.O. Box 517
Frankfort, KY 40602
(502) 564-3630

Louisiana
Louisiana Insurance Department
P.O. Box 94214
Baton Rouge, LA 70804-9214
(504) 342-5900

Maine
Maine Bureau of Insurance
Consumer Division
State House, Station 34
Augusta, ME 04333
(207) 582-8707

Maryland
Maryland Insurance Department
Complaints and Investigation Unit
501 St. Paul Place
Baltimore, MD 21202-2272
(301) 333-6300

Massachusetts
Massachusetts Insurance Division
Consumer Services Section
280 Friend Street
Boston, MA 02114
(617) 727-7189

Michigan
Michigan Insurance Department
P.O. Box 30220
Lansing, MI 48909
(517) 373-0220

Minnesota
Minnesota Insurance Department
Department of Commerce
133 E. 7th Street
St. Paul, MN 55101
(612) 296-4026

Mississippi
Mississippi Insurance Department
Consumer Assistance Division
P.O. Box 79
Jackson, MS 39205
(601) 359-3569

Missouri
Missouri Department of Insurance
Consumer Services Section
P.O. Box 690
Jefferson City, MO 65102-0690
(314) 751-2640
Toll Free (Within State)
1-800-726-7390

Montana
Montana Insurance Department
126 N. Sanders
Mitchell Building
P.O. Box 4009, Room 270
Helena, MT 59604
Toll Free (Within State)
1-800-332-6148
(406) 444-2040

Nebraska
Nebraska Insurance Department
Terminal Building
941 O Street, Suite 400
Lincoln, NE 68508
(402) 471-2201

Nevada
Nevada Department of Commerce
Insurance Division
Consumer Section
1665 Hot Springs Road
Capitol Complex
Carson City, NV 89701
(702) 687-4270

New Hampshire
New Hampshire Insurance Department
Life and Health Division
169 Manchester Street
Concord, NH 03301
(603) 271-2261

New Jersey
New Jersey Insurance Department
20 West State Street
Roebling Building
Trenton, NJ 08625
(609) 292-4757

New Mexico
New Mexico Insurance Department
P.O. Box 1269
Santa Fe, NM 87504-1269
(505) 827-4500

New York
New York Insurance Department
160 West Broadway
New York, NY 10013
New York City
(212) 602-0203
Toll Free (Within State outside of NYC)
1-800-342-3736

North Carolina
North Carolina Insurance Department
Consumer Services
Dobbs Building
P.O. Box 26387
Raleigh, NC 27611
(919) 733-2004

North Dakota
North Dakota Insurance Department
Capitol Building
5th Floor
Bismarck, ND 58505
(701) 224-2440
Toll Free (Within State)
1-800-247-0560

Ohio
Ohio Insurance Department
Consumer Services Division
2100 Stella Court
Columbus, OH 43266-0566
Toll Free (Within State)
1-800-686-1526
(614) 644-2673

Oklahoma
Oklahoma Insurance Department
P.O. Box 53408
Oklahoma City, OK 73152-3408
(405) 521-2828

Oregon
Oregon Department of Insurance and Finance
Insurance Division/Consumer Advocate
440 Labor and Industries Building
Salem, OR 97310
(503) 378-4484

Pennsylvania
Pennsylvania Insurance Department
Consumer Services Bureau
1321 Strawberry Square
Harrisburg, PA 17120
(717) 787-2317

Puerto Rico
Puerto Rico Insurance Department
Fernandez Juncos Station
P.O. Box 8330
Santurce, PR 00910
(809) 722-8686

Rhode Island
Rhode Island Insurance Division
233 Richmond Street
Suite 233
Providence, RI 02903-4233
(401) 277-2223

South Carolina
South Carolina Insurance Department
Consumer Assistance Section
P.O. Box 100105
Columbia, SC 29202-3105
(803) 737-6140

South Dakota
South Dakota Insurance Department
Enforcement
910 E. Sioux Avenue
Pierre, SD 57501-3940
(605) 773-3563

Tennessee
Tennessee Department of Commerce
and Insurance
Policyholders Service Section
4th Floor
500 James Robertson Parkway
Nashville, TN 3737243-0582
Toll Free (Within State)
1-800-342-4029
(615) 741-2218

Texas
Texas Board of Insurance
Complaints Division
1110 San Jacinto Blvd.
Austin, TX 78701-1998
(512) 463-6501

Utah
Utah Insurance Department
Consumer Services
3110 State Office Building
Salt Lake City, UT 84114
Toll Free (Within State)
1-800-439-3805
(801) 538-3805

Vermont
Vermont Department of Banking and Insurance
Consumer Complaint Division
120 State Street
Montpelier, VT 05602
(802) 828-3301

Virgin Island
Virgin Islands Insurance Department
Kongens Garde No. 18
St. Thomas, VI 00802
(809) 774-2991

Virginia
Virginia Insurance Department
Consumer Services Division
700 Jefferson Building
P.O. Box 1157
Richmond, VA 23209
(804) 786-7691

Washington
Washington Insurance Department
Insurance Building AQ21
Olympia, WA 98504-0321
Toll Free (Within State)
1-800-562-6900
(206) 753-7300

West Virginia
West Virginia Insurance Department
2019 Washington Street, E
Charleston, WV 25305
(304) 348-3386

Wisconsin
Wisconsin Insurance Department
Complaints Department
P.O. Box 7873
Madison, WI 53707
Toll Free (Within State)
1-800-236-8517
(608) 266-0103

Wyoming
Wyoming Insurance Department
Herschler Building
122 W. 25th Street
Cheyenne, WY 82002
Toll Free (Within State)
1-800-442-4333
(307) 777-7401

The offices listed in this section are responsible for coordinating services for older Americans.

Alabama
Commission on Aging
770 Washington Avenue
Montgomery, AL 36130
Toll Free (Within State)
1-800-243-5463
(205) 242-5743

Alaska
Older Alaskans Commission
P.O. Box C, MS 0209
Juneau, AK 99811
(907) 465-3250

American Samoa
Territorial Administration on Aging
Government of American Samoa
Pago Pago, AS 96799
(684) 633-1251

Arizona
Department of Economic Security
Aging and Adult Administration
1400 W. Washington Street
Phoenix, AZ 85007
(602) 542-4446

Arkansas
Division of Aging and Adult Services
Donaghey Plaza South
Suite 1417
7th and Main Streets
P.O. Box 1417/Slot 1412
Little Rock, AR 72203-1437
(501) 682-2441

California
Department of Aging
1600 K Street
Sacramento,CA 95814
(916) 322-3887

Colorado
Aging and Adult Services
Department of Social Services
1575 Sherman St., 10th Floor
Denver, CO 80203-1714
(303) 866-3851

Commonwealth of the Northern Mariana Islands
Department of Community and Cultural Affairs
Civic Center
Commonwealth of the Northern Mariana Islands
Saipan, CM 96950
(607) 234-6011

Connecticut
Department on Aging
175 Main Street
Hartford, CT 06106
Toll Free (Within State)
1-800-443-9946
(203) 566-7772

Delaware
Division of Aging
Department of Health and Social Services
1901 N. DuPont Highway
New Castle, DE 19720
(302) 421-6791

District of Columbia
Office on Aging
1424 K Street, NW., 2nd Floor
Washington, DC 20005
(202) 724-5626
(202) 724-5622

Federated States of Micronesia
State Agency on Aging
Office of Health Services
Federated States of Micronesia
Ponape, E.C.I. 96941

Florida
Office of Aging and Adult Services
1317 Winewood Boulevard
Tallahassee, FL 32301
(904) 488-8922

Georgia
Office of Aging
Department of Human Resources
878 Peachtree Street, NE., Room 632
Atlanta, GA 30309
(404) 894-5333

Guam
Division of Senior Citizens
Department of Public Health and Social Services
P.O. Box 2816
Agana, GU 96910
(671) 734-4361

Hawaii
Executive Office on Aging
335 Merchant Street
Room 241
Honolulu, HI 96813
(808) 586-0100

Idaho
Office on Aging
Statehouse, Room 108
Boise, ID 83720
(208) 334-3833

Illinois
Department on Aging
421 E. Captiol Avenue
Springfield, IL 62701
(217) 785-2870

Indiana
Department of Human Services
251 North Illinois Street
P.O. Box 7083
Indianapolis, IN 46207-7083
(317) 232-7020

Iowa
Department of Elder Affairs
Jewett Building, Suite 236
914 Grand Avenue
Des Moines, IA 50319
(515) 281-5187

Kansas
Department on Aging
122-S Docking State Office Building
915 SW Harrison
Topeka, KS 66612-1500
(913) 296-4986

Kentucky
Division for Aging Services
Department for Social Services
275 E. Main Street
Frankfort, KY 40621
(502) 564-6930

Louisiana
Governor's Office of Elderly Affairs
P.O. Box 80374
Baton Rouge, LA 70898-0374
(504) 925-1700

Maine
Bureau of Elder & Adult Services
State House, Station 11
Augusta, ME 04333
(207) 624-5335

Maryland
State Agency on Aging
301 W. Preston Street, room 1004
Baltimore, MD 21201
(301) 225-1102

Massachusetts
Executive Office of Elder Affairs
38 Chauncy Street
Boston, MA 02111
Toll Free (Within State)
1-800-882-2003
(617) 727-7750

Michigan
Office of Services to the Aging
P.O. Box 30026
Lansing, MI 48909
(517) 373-8230

Minnesota
Minnesota Board on Aging
Human Services Building
4th Floor
444 Lafayette Road
St. Paul MN 55155-3843
(612) 296-2770

Mississippi
Council on Aging
421 W. Pascagoula Street
Jackson, MS 39203-3524
Toll Free (Within State)
1-800-222-7622
(601) 949-2070

Missouri
Division of Aging
Department of Social Services
P.O. Box 1337 - 615 Howerton Court
Jefferson, MO 65102-1337
(314) 751-3082

Montana
The Governor's Office on Aging
State Capital Building, Room 219
Helena, MT 59620
Toll Free (Within State
1-800-332-2272(406) 444-3111

Nebraska
Department on Aging
State Office Building
301 Centennial Mall South
Lincoln, NE 68509
(402) 471-2306

Nevada
Department of Human Resources
Division for Aging Services
340 No 11th Street, Suite 114
Las Vegas, NV 89101
(702) 687-4210

New Hampshire
Department of Health and Human Services
Division of Elderly and Adult Services
6 Hazen Drive
Concord, NH 03301
(603) 271-4680

New Jersey
Department of Community Affairs
Division on Aging
S. Broad and Front Sts., CN 807
Trenton, NJ 08625-0807
Toll Free (Within State)
1-800-792-8820
(609) 292-0920

New Mexico
Agency on Aging
La Villa Rivera Bldg., 4th Floor
224 E. Palace Avenue
Santa Fe, NM 87501
Toll Free (Within State)
1-800-432-2080
(505) 827-7640

New York
State Office for the Aging
2 Empire State Plaza
Albany, NY 12223-0001
Toll Free (Within State)
1-800-342-9871
(518) 474-5731

North Carolina
Department of Human Resources
Division of Aging
693 Palmer Drive
Raleigh, NC 27626-0531
(919) 733-3983

North Dakota
Department of Human Services
Aging Services Division
State Capitol Building
Bismarck, ND 58505
(701) 224-2577

Ohio
Department of Aging
50 W. Broad Street
8th Floor
Columbus, OH 43266-0501
(614) 466-1221

Oklahoma
Department of Human Services
Aging Services Division
P.O. Box 25352
Oklahoma City, OK 73125
(405) 521-2327

Oregon
Department of Human Resources
Senior Services Division
313 Public Service Building
Salem, OR 97310
Toll Free (Within State)
1-800-232-3020
(503) 378-4728

Palau
State Agency on Aging
Department of Social Services
Republic of Palau
Koror, Palau 96940

Pennsylvania
Department of Aging
231 State Street
Barto Building
Harrisburg, PA 17101
(717) 783-1550

Puerto Rico
Governors Office of Elderly Affairs
Gericulture Commission
Box 11398
Santurce, PR 00910
(809) 722-2429 or 722-0225

Republic of the Marshall Islands
State Agency on Aging
Department of Social Services
Republic of the Marshall Islands
Marjuro, Marshall Islands 96960

Rhode Island
Department of Elderly Affairs
160 Pine Street
Providence, RI 02903
(401) 277-2858

South Carolina
Commission on Aging
400 Arbor Lake Drive
Suite B-500
Columbia, SC 29223
(803) 735-0210

South Dakota
Agency on Aging
Adult Services and Aging
Richard F. Kneip Building
700 Governors Drive
Pierre, SD 57501-2291
(605) 773-3656

Tennessee
Commission on Aging
706 Church Street
Suite 201
Nashville, TN 37219-5573
(615) 741-2056

Texas
Department on Aging
P.O. Box 12786
Capitol Station
Austin, TX 78741-3702
(512) 444-2727

Utah
Division of Aging and Adult Services
120 North 200 West
P.O. Box 45500
Salt Lake City, UT 84145-0500
(801) 538-3910

Vermont
Office on Aging
Waterbury Complex
103 S. Main Street
Waterbury, VT 05676
(802) 241-2400

Virginia
Department for the Aging
700 Centre, 10th Floor
700 E. Franklin Street
Richmond, VA 23219-2327
Toll Free (Within State)
1-800-552-4464
(804) 225-2271

Virgin Islands
Department of Human Services
19 Estate Diamond Frederick Sted
St. Croix, VI 00840
(809) 772-4850

Washington
Aging & Adult Services Administration
Department of Social and Health Services
Mail Stop OB-44-A
Olympia, WA 98504
(206) 586-3768

West Virginia
Commission on Aging
State Capitol Complex
Holly Grove
Charleston, WV 25305
Toll Free (Within State)
1-800-642-3671
(304) 348-3317

Wisconsin
Bureau on Aging
Department of Health and Social Services
P.O. Box 7851
Madison, WI 53707
Toll Free (Within State)
1-800-242-1060
(608) 266-2536

Wyoming
Commission on Aging
Hathaway Building
First Floor
Cheyenne, WY 82002
Toll Free (Within State)
1-800-442-2766
(307) 777-7986

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POLICY CHECK-LIST

After reading this guide, you may find this check-list useful in assessing the benefits provided by a Medigap policy or in comparing policies.

Does the policy cover:	POLICY 1 YES	POLICY 1 NO	POLICY 2 YES	POLICY 2 NO	POLICY 3 YES	POLICY 3 NO
Medicare Part A hospital deductible?	☐	☐	☐	☐	☐	☐
*Medicare Part A hospital daily coinsurance?	☐	☐	☐	☐	☐	☐
*Hospital care beyond Medicare's 150-day limit?	☐	☐	☐	☐	☐	☐
Skilled nursing facility (SNF) daily coinsurance?	☐	☐	☐	☐	☐	☐
SNF care beyond Medicare's limits?	☐	☐	☐	☐	☐	☐
Medicare Part B annual deductible?	☐	☐	☐	☐	☐	☐
*Medicare Part B coinsurance?	☐	☐	☐	☐	☐	☐
Physician and supplier charges in excess of Medicare's approved amounts?	☐	☐	☐	☐	☐	☐
*Medicare blood deductibles?	☐	☐	☐	☐	☐	☐

Other Policy Considerations

Can the company cancel or non-renew the policy?	☐	☐	☐	☐	☐	☐
What are the policy limits for covered services?	—	—	—	—	—	—
How much is the annual premium?	—	—	—	—	—	—
How often can the company raise the premium?	—	—	—	—	—	—
How long before existing health problems are covered?	—	—	—	—	—	—
Does the policy have a waiting period before any benefits will be paid? How long?	—	—	—	—	—	—

* Most states now require that these benefits be included in all newly issued Medigap policies

U.S. Department of Health and Human Services
Health Care Financing Administration
6325 Security Boulevard
Baltimore, Maryland 21207

U.S. Department of Health and Human Services
Health Care Financing Administration
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